



Senate

General Assembly

File No. 58

February Session, 2014

Senate Bill No. 186

Senate, March 19, 2014

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

***AN ACT CONCERNING DISPENSATION AND INSURANCE
COVERAGE OF A PRESCRIBED DRUG DURING REVIEW OF AN
ADVERSE DETERMINATION OR A FINAL ADVERSE
DETERMINATION.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-591d of the 2014 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective January 1, 2015*):

4 (a) (1) Each health carrier shall maintain written procedures for (A)
5 utilization review and benefit determinations, (B) expedited utilization
6 review and benefit determinations with respect to prospective urgent
7 care requests and concurrent review urgent care requests, and (C)
8 notifying covered persons or covered persons' authorized
9 representatives of such review and benefit determinations. Each health
10 carrier shall make such review and benefit determinations within the
11 specified time periods under this section.

12 (2) In determining whether a benefit request shall be considered an

13 urgent care request, an individual acting on behalf of a health carrier
14 shall apply the judgment of a prudent layperson who possesses an
15 average knowledge of health and medicine, except that any benefit
16 request (A) determined to be an urgent care request by a health care
17 professional with knowledge of the covered person's medical
18 condition, or (B) specified under subparagraph (B) or (C) of
19 subdivision (38) of section 38a-591a shall be deemed an urgent care
20 request.

21 (3) After a covered person, a covered person's authorized
22 representative or a covered person's health care professional is notified
23 of an initial adverse determination that was based, in whole or in part,
24 on medical necessity, of a concurrent or prospective utilization review
25 or of a benefit request, a health carrier may offer a covered person's
26 health care professional the opportunity to confer with a clinical peer
27 of such health carrier, provided such covered person, covered person's
28 authorized representative or covered person's health care professional
29 has not filed a grievance of such initial adverse determination prior to
30 such conference. Such conference shall not be considered a grievance
31 of such initial adverse determination.

32 (b) With respect to a nonurgent care request:

33 (1) (A) For a prospective or concurrent review request, a health
34 carrier shall make a determination within a reasonable period of time
35 appropriate to the covered person's medical condition, but not later
36 than fifteen calendar days after the date the health carrier receives such
37 request, and shall notify the covered person and, if applicable, the
38 covered person's authorized representative of such determination,
39 whether or not the carrier certifies the provision of the benefit.

40 (B) If the review under subparagraph (A) of this subdivision is a
41 review of a grievance involving a concurrent review request, pursuant
42 to 45 CFR 147.136, as amended from time to time, the treatment shall
43 be continued without liability to the covered person until the covered
44 person has been notified of the review decision.

45 (C) Notwithstanding subparagraph (B) of this subdivision, if a
46 covered person or the covered person's authorized representative files
47 any grievance or requests any review of an adverse determination
48 pursuant to this section relating to the dispensation of a drug
49 prescribed by a licensed participating provider, the health carrier shall
50 issue immediate electronic authorization to the covered person's
51 pharmacy for the duration of any such grievance or review. Such
52 authorization shall include confirmation of the availability of payment
53 for such supply of such drug.

54 (2) For a retrospective review request, a health carrier shall make a
55 determination within a reasonable period of time, but not later than
56 thirty calendar days after the date the health carrier receives such
57 request.

58 (3) The time periods specified in subdivisions (1) and (2) of this
59 subsection may be extended once by the health carrier for up to fifteen
60 calendar days, provided the health carrier:

61 (A) Determines that an extension is necessary due to circumstances
62 beyond the health carrier's control; and

63 (B) Notifies the covered person and, if applicable, the covered
64 person's authorized representative prior to the expiration of the initial
65 time period, of the circumstances requiring the extension of time and
66 the date by which the health carrier expects to make a determination.

67 (4) (A) If the extension pursuant to subdivision (3) of this subsection
68 is necessary due to the failure of the covered person or the covered
69 person's authorized representative to provide information necessary to
70 make a determination on the request, the health carrier shall:

71 (i) Specifically describe in the notice of extension the required
72 information necessary to complete the request; and

73 (ii) Provide the covered person and, if applicable, the covered
74 person's authorized representative with not less than forty-five
75 calendar days after the date of receipt of the notice to provide the

76 specified information.

77 (B) If the covered person or the covered person's authorized
78 representative fails to submit the specified information before the end
79 of the period of the extension, the health carrier may deny certification
80 of the benefit requested.

81 (c) With respect to an urgent care request:

82 (1) (A) Unless the covered person or the covered person's
83 authorized representative has failed to provide information necessary
84 for the health carrier to make a determination and except as specified
85 under subparagraph (B) of this subdivision, the health carrier shall
86 make a determination as soon as possible, taking into account the
87 covered person's medical condition, but not later than seventy-two
88 hours after the health carrier receives such request, provided, if the
89 urgent care request is a concurrent review request to extend a course of
90 treatment beyond the initial period of time or the number of
91 treatments, such request is made at least twenty-four hours prior to the
92 expiration of the prescribed period of time or number of treatments.

93 (B) Unless the covered person or the covered person's authorized
94 representative has failed to provide information necessary for the
95 health carrier to make a determination, for an urgent care request
96 specified under subparagraph (B) or (C) of subdivision (38) of section
97 38a-591a, the health carrier shall make a determination as soon as
98 possible, taking into account the covered person's medical condition,
99 but not later than twenty-four hours after the health carrier receives
100 such request, provided, if the urgent care request is a concurrent
101 review request to extend a course of treatment beyond the initial
102 period of time or the number of treatments, such request is made at
103 least twenty-four hours prior to the expiration of the prescribed period
104 of time or number of treatments.

105 (2) (A) If the covered person or the covered person's authorized
106 representative has failed to provide information necessary for the
107 health carrier to make a determination, the health carrier shall notify

108 the covered person or the covered person's representative, as
109 applicable, as soon as possible, but not later than twenty-four hours
110 after the health carrier receives such request.

111 (B) The health carrier shall provide the covered person or the
112 covered person's authorized representative, as applicable, a reasonable
113 period of time to submit the specified information, taking into account
114 the covered person's medical condition, but not less than forty-eight
115 hours after notifying the covered person or the covered person's
116 authorized representative, as applicable.

117 (3) The health carrier shall notify the covered person and, if
118 applicable, the covered person's authorized representative of its
119 determination as soon as possible, but not later than forty-eight hours
120 after the earlier of (A) the date on which the covered person and the
121 covered person's authorized representative, as applicable, provides the
122 specified information to the health carrier, or (B) the date on which the
123 specified information was to have been submitted.

124 (d) (1) Whenever a health carrier receives a review request from a
125 covered person or a covered person's authorized representative that
126 fails to meet the health carrier's filing procedures, the health carrier
127 shall notify the covered person and, if applicable, the covered person's
128 authorized representative of such failure not later than five calendar
129 days after the health carrier receives such request, except that for an
130 urgent care request, the health carrier shall notify the covered person
131 and, if applicable, the covered person's authorized representative of
132 such failure not later than twenty-four hours after the health carrier
133 receives such request.

134 (2) If the health carrier provides such notice orally, the health carrier
135 shall provide confirmation in writing to the covered person and the
136 covered person's health care professional of record not later than five
137 calendar days after providing the oral notice.

138 (e) Each health carrier shall provide promptly to a covered person
139 and, if applicable, the covered person's authorized representative a

140 notice of an adverse determination.

141 (1) Such notice may be provided in writing or by electronic means
142 and shall set forth, in a manner calculated to be understood by the
143 covered person or the covered person's authorized representative:

144 (A) Information sufficient to identify the benefit request or claim
145 involved, including the date of service, if applicable, the health care
146 professional and the claim amount;

147 (B) The specific reason or reasons for the adverse determination,
148 including, upon request, a listing of the relevant clinical review
149 criteria, including professional criteria and medical or scientific
150 evidence and a description of the health carrier's standard, if any, that
151 were used in reaching the denial;

152 (C) Reference to the specific health benefit plan provisions on which
153 the determination is based;

154 (D) A description of any additional material or information
155 necessary for the covered person to perfect the benefit request or claim,
156 including an explanation of why the material or information is
157 necessary to perfect the request or claim;

158 (E) A description of the health carrier's internal grievance process
159 that includes (i) the health carrier's expedited review procedures, (ii)
160 any time limits applicable to such process or procedures, (iii) the
161 contact information for the organizational unit designated to
162 coordinate the review on behalf of the health carrier, and (iv) a
163 statement that the covered person or, if applicable, the covered
164 person's authorized representative is entitled, pursuant to the
165 requirements of the health carrier's internal grievance process, to
166 receive from the health carrier, free of charge upon request, reasonable
167 access to and copies of all documents, records, communications and
168 other information and evidence regarding the covered person's benefit
169 request;

170 (F) If the adverse determination is based on a health carrier's

171 internal rule, guideline, protocol or other similar criterion, (i) the
172 specific rule, guideline, protocol or other similar criterion, or (ii) (I) a
173 statement that a specific rule, guideline, protocol or other similar
174 criterion of the health carrier was relied upon to make the adverse
175 determination and that a copy of such rule, guideline, protocol or other
176 similar criterion will be provided to the covered person free of charge
177 upon request, (II) instructions for requesting such copy, and (III) the
178 links to such rule, guideline, protocol or other similar criterion on such
179 health carrier's Internet web site. If the adverse determination involves
180 the treatment of a substance use disorder, as described in section 17a-
181 458, or a mental disorder, the notice of adverse determination shall
182 also include, if applicable, a link to the document created and
183 maintained by such health carrier pursuant to subdivision (3), (4) or (5)
184 of subsection (a) of section 38a-591c, as applicable, on such health
185 carrier's Internet web site;

186 (G) If the adverse determination is based on medical necessity or an
187 experimental or investigational treatment or similar exclusion or limit,
188 the written statement of the scientific or clinical rationale for the
189 adverse determination and (i) an explanation of the scientific or clinical
190 rationale used to make the determination that applies the terms of the
191 health benefit plan to the covered person's medical circumstances or
192 (ii) a statement that an explanation will be provided to the covered
193 person free of charge upon request, and instructions for requesting a
194 copy of such explanation;

195 (H) A statement explaining the right of the covered person to
196 contact the commissioner's office or the Office of the Healthcare
197 Advocate at any time for assistance or, upon completion of the health
198 carrier's internal grievance process, to file a civil suit in a court of
199 competent jurisdiction. Such statement shall include the contact
200 information for said offices; and

201 (I) A statement that if the covered person or the covered person's
202 authorized representative chooses to file a grievance of an adverse
203 determination, (i) such appeals are sometimes successful, (ii) such

covered person or covered person's authorized representative may benefit from free assistance from the Office of the Healthcare Advocate, which can assist such covered person or covered person's authorized representative with the filing of a grievance pursuant to 42 USC 300gg-93, as amended from time to time, or from the Division of Consumer Affairs within the Insurance Department, (iii) such covered person or covered person's authorized representative is entitled and encouraged to submit supporting documentation for the health carrier's consideration during the review of an adverse determination, including narratives from such covered person or covered person's authorized representative and letters and treatment notes from such covered person's health care professional, and (iv) such covered person or covered person's authorized representative has the right to ask such covered person's health care professional for such letters or treatment notes.

(2) Upon request pursuant to subparagraph (E) of subdivision (1) of this subsection, the health carrier shall provide such copies in accordance with subsection (a) of section 38a-591n.

(f) If the adverse determination is a rescission, the health carrier shall include with the advance notice of the application for rescission required to be sent to the covered person, a written statement that includes:

(1) Clear identification of the alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact;

(2) An explanation as to why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact;

(3) A disclosure that the covered person or the covered person's authorized representative may file immediately, without waiting for the date such advance notice of the proposed rescission ends, a grievance with the health carrier to request a review of the adverse determination to rescind coverage, pursuant to sections 38a-591e and 38a-591f;

236 (4) A description of the health carrier's grievance procedures
237 established under sections 38a-591e and 38a-591f, including any time
238 limits applicable to those procedures; and

239 (5) The date such advance notice of the proposed rescission ends
240 and the date back to which the coverage will be retroactively
241 rescinded.

242 (g) (1) Whenever a health carrier fails to strictly adhere to the
243 requirements of this section with respect to making utilization review
244 and benefit determinations of a benefit request or claim, the covered
245 person shall be deemed to have exhausted the internal grievance
246 process of such health carrier and may file a request for an external
247 review in accordance with the provisions of section 38a-591g,
248 regardless of whether the health carrier asserts it substantially
249 complied with the requirements of this section or that any error it
250 committed was de minimis.

251 (2) A covered person who has exhausted the internal grievance
252 process of a health carrier may, in addition to filing a request for an
253 external review, pursue any available remedies under state or federal
254 law on the basis that the health carrier failed to provide a reasonable
255 internal grievance process that would yield a decision on the merits of
256 the claim.

257 Sec. 2. Section 38a-591e of the 2014 supplement to the general
258 statutes is repealed and the following is substituted in lieu thereof
259 (*Effective January 1, 2015*):

260 (a) (1) Each health carrier shall establish and maintain written
261 procedures for (A) the review of grievances of adverse determinations
262 that were based, in whole or in part, on medical necessity, (B) the
263 expedited review of grievances of adverse determinations of urgent
264 care requests, including concurrent review urgent care requests
265 involving an admission, availability of care, continued stay or health
266 care service for a covered person who has received emergency services
267 but has not been discharged from a facility, and (C) notifying covered

268 persons or covered persons' authorized representatives of such
269 adverse determinations.

270 (2) Each health carrier shall file with the commissioner a copy of
271 such procedures, including all forms used to process requests, and any
272 subsequent material modifications to such procedures.

273 (3) In addition to a copy of such procedures, each health carrier shall
274 file annually with the commissioner, as part of its annual report
275 required under subsection (e) of section 38a-591b, a certificate of
276 compliance stating that the health carrier has established and
277 maintains grievance procedures for each of its health benefit plans that
278 are fully compliant with the provisions of sections 38a-591a to 38a-
279 591n, inclusive.

280 (b) (1) A covered person or a covered person's authorized
281 representative may file a grievance of an adverse determination that
282 was based, in whole or in part, on medical necessity with the health
283 carrier not later than one hundred eighty calendar days after the
284 covered person or the covered person's authorized representative, as
285 applicable, receives the notice of an adverse determination.

286 (2) For prospective or concurrent urgent care requests, a covered
287 person or a covered person's authorized representative may make a
288 request for an expedited review orally or in writing.

289 (c) (1) (A) When conducting a review of an adverse determination
290 under this section, the health carrier shall ensure that such review is
291 conducted in a manner to ensure the independence and impartiality of
292 the clinical peer or peers involved in making the review decision.

293 (B) If the adverse determination involves utilization review, the
294 health carrier shall designate an appropriate clinical peer or peers to
295 review such adverse determination. Such clinical peer or peers shall
296 not have been involved in the initial adverse determination.

297 (C) The clinical peer or peers conducting a review under this section
298 shall take into consideration all comments, documents, records and

299 other information relevant to the covered person's benefit request that
300 is the subject of the adverse determination under review, that are
301 submitted by the covered person or the covered person's authorized
302 representative, regardless of whether such information was submitted
303 or considered in making the initial adverse determination.

304 (D) Prior to issuing a decision, the health carrier shall provide free
305 of charge, by facsimile, electronic means or any other expeditious
306 method available, to the covered person or the covered person's
307 authorized representative, as applicable, any new or additional
308 documents, communications, information and evidence relied upon
309 and any new or additional scientific or clinical rationale used by the
310 health carrier in connection with the grievance. Such documents,
311 communications, information, evidence and rationale shall be
312 provided sufficiently in advance of the date the health carrier is
313 required to issue a decision to permit the covered person or the
314 covered person's authorized representative, as applicable, a reasonable
315 opportunity to respond prior to such date.

316 (2) If the review under subdivision (1) of this subsection is an
317 expedited review, all necessary information, including the health
318 carrier's decision, shall be transmitted between the health carrier and
319 the covered person or the covered person's authorized representative,
320 as applicable, by telephone, facsimile, electronic means or any other
321 expeditious method available.

322 (3) If the review under subdivision (1) of this subsection is an
323 expedited review of a grievance involving an adverse determination of
324 a concurrent review request, pursuant to 45 CFR 147.136, as amended
325 from time to time, the treatment shall be continued without liability to
326 the covered person until the covered person has been notified of the
327 review decision.

328 (4) Notwithstanding subdivision (3) of this subsection, if a covered
329 person or the covered person's authorized representative files any
330 grievance or requests any review of an adverse determination
331 pursuant to this section relating to the dispensation of a drug

332 prescribed by a licensed participating provider, the health carrier shall
333 issue immediate electronic authorization to the covered person's
334 pharmacy for the duration of any such grievance or review. Such
335 authorization shall include confirmation of the availability of payment
336 for such supply of such drug.

337 (d) (1) The health carrier shall notify the covered person and, if
338 applicable, the covered person's authorized representative, in writing
339 or by electronic means, of its decision within a reasonable period of
340 time appropriate to the covered person's medical condition, but not
341 later than:

342 (A) For prospective review and concurrent review requests, thirty
343 calendar days after the health carrier receives the grievance;

344 (B) For retrospective review requests, sixty calendar days after the
345 health carrier receives the grievance;

346 (C) For expedited review requests, except as specified under
347 subparagraph (D) of this subdivision, seventy-two hours after the
348 health carrier receives the grievance; and

349 (D) For expedited review requests of a health care service or course
350 of treatment specified under subparagraph (B) or (C) of subdivision
351 (38) of section 38a-591a, twenty-four hours after the health carrier
352 receives the grievance.

353 (2) The time periods set forth in subdivision (1) of this subsection
354 shall apply regardless of whether all of the information necessary to
355 make a decision accompanies the filing.

356 (e) (1) The notice required under subsection (d) of this section shall
357 set forth, in a manner calculated to be understood by the covered
358 person or the covered person's authorized representative:

359 (A) The titles and qualifying credentials of the clinical peer or peers
360 participating in the review process;

361 (B) Information sufficient to identify the claim involved with respect
362 to the grievance, including the date of service, if applicable, the health
363 care professional and the claim amount;

364 (C) A statement of such clinical peer's or peers' understanding of the
365 covered person's grievance;

366 (D) The clinical peer's or peers' decision in clear terms and the
367 health benefit plan contract basis or scientific or clinical rationale for
368 such decision in sufficient detail for the covered person to respond
369 further to the health carrier's position;

370 (E) Reference to the evidence or documentation used as the basis for
371 the decision;

372 (F) For a decision that upholds the adverse determination:

373 (i) The specific reason or reasons for the final adverse
374 determination, including the denial code and its corresponding
375 meaning, as well as a description of the health carrier's standard, if
376 any, that was used in reaching the denial;

377 (ii) Reference to the specific health benefit plan provisions on which
378 the decision is based;

379 (iii) A statement that the covered person may receive from the
380 health carrier, free of charge and upon request, reasonable access to
381 and copies of, all documents, records, communications and other
382 information and evidence not previously provided regarding the
383 adverse determination under review;

384 (iv) If the final adverse determination is based on a health carrier's
385 internal rule, guideline, protocol or other similar criterion, (I) the
386 specific rule, guideline, protocol or other similar criterion, or (II) a
387 statement that a specific rule, guideline, protocol or other similar
388 criterion of the health carrier was relied upon to make the final adverse
389 determination and that a copy of such rule, guideline, protocol or other
390 similar criterion will be provided to the covered person free of charge

391 upon request and instructions for requesting such copy;

392 (v) If the final adverse determination is based on medical necessity
393 or an experimental or investigational treatment or similar exclusion or
394 limit, the written statement of the scientific or clinical rationale for the
395 final adverse determination and (I) an explanation of the scientific or
396 clinical rationale used to make the determination that applies the terms
397 of the health benefit plan to the covered person's medical
398 circumstances, or (II) a statement that an explanation will be provided
399 to the covered person free of charge upon request and instructions for
400 requesting a copy of such explanation;

401 (vi) A statement describing the procedures for obtaining an external
402 review of the final adverse determination;

403 (G) If applicable, the following statement: "You and your plan may
404 have other voluntary alternative dispute resolution options such as
405 mediation. One way to find out what may be available is to contact
406 your state Insurance Commissioner."; and

407 (H) A statement disclosing the covered person's right to contact the
408 commissioner's office or the Office of the Healthcare Advocate at any
409 time. Such disclosure shall include the contact information for said
410 offices.

411 (2) Upon request pursuant to subparagraph (F)(iii) of subdivision (1)
412 of this subsection, the health carrier shall provide such copies in
413 accordance with subsection (b) of section 38a-591n.

414 (f) (1) Whenever a health carrier fails to strictly adhere to the
415 requirements of this section with respect to receiving and resolving
416 grievances involving an adverse determination, the covered person
417 shall be deemed to have exhausted the internal grievance process of
418 such health carrier and may file a request for an external review,
419 regardless of whether the health carrier asserts that it substantially
420 complied with the requirements of this section, or that any error it
421 committed was de minimis.

422 (2) A covered person who has exhausted the internal grievance
423 process of a health carrier may, in addition to filing a request for an
424 external review, pursue any available remedies under state or federal
425 law on the basis that the health carrier failed to provide a reasonable
426 internal grievance process that would yield a decision on the merits of
427 the claim.

428 Sec. 3. Section 38a-591f of the 2014 supplement to the general
429 statutes is repealed and the following is substituted in lieu thereof
430 (*Effective January 1, 2015*):

431 (a) Each health carrier shall establish and maintain written
432 procedures for (1) the review of grievances of adverse determinations
433 that were not based on medical necessity, and (2) notifying covered
434 persons or covered persons' authorized representatives of such
435 adverse determinations.

436 (b) (1) A covered person or the covered person's authorized
437 representative may file a grievance of an adverse determination that
438 was not based on medical necessity with the health carrier not later
439 than one hundred eighty calendar days after the covered person or the
440 covered person's representative, as applicable, receives the notice of an
441 adverse determination.

442 (2) If a covered person or the covered person's authorized
443 representative files any grievance or requests any review of an adverse
444 determination pursuant to this section relating to the dispensation of a
445 drug prescribed by a licensed participating provider, the health carrier
446 shall issue immediate electronic authorization to the covered person's
447 pharmacy for the duration of any such grievance or review. Such
448 authorization shall include confirmation of the availability of payment
449 for such supply of such drug.

450 [(2)] (3) The health carrier shall notify the covered person and, if
451 applicable, the covered person's authorized representative not later
452 than three business days after the health carrier receives a grievance
453 that the covered person or the covered person's authorized

454 representative, as applicable, is entitled to submit written material to
455 the health carrier to be considered when conducting a review of the
456 grievance.

457 [(3)] (4) (A) Upon receipt of a grievance, a health carrier shall
458 designate an individual or individuals to conduct a review of the
459 grievance.

460 (B) The health carrier shall not designate the same individual or
461 individuals who denied the claim or handled the matter that is the
462 subject of the grievance to conduct the review of the grievance.

463 (C) The health carrier shall provide the covered person and, if
464 applicable, the covered person's authorized representative with the
465 name, address and telephone number of the individual or the
466 organizational unit designated to coordinate the review on behalf of
467 the health carrier.

468 (c) (1) The health carrier shall notify the covered person and, if
469 applicable, the covered person's authorized representative in writing,
470 of its decision not later than twenty business days after the health
471 carrier received the grievance.

472 (2) If the health carrier is unable to comply with the time period
473 specified in subdivision (1) of this subsection due to circumstances
474 beyond the health carrier's control, the time period may be extended
475 by the health carrier for up to ten business days, provided that on or
476 before the twentieth business day after the health carrier received the
477 grievance, the health carrier provides written notice to the covered
478 person and, if applicable, the covered person's authorized
479 representative of the extension and the reasons for the delay.

480 (d) (1) The written decision issued pursuant to subsection (c) of this
481 section shall contain:

482 (A) The titles and qualifying credentials of the individual or
483 individuals participating in the review process;

484 (B) A statement of such individual's or individuals' understanding
485 of the covered person's grievance;

486 (C) The individual's or individuals' decision in clear terms and the
487 health benefit plan contract basis for such decision in sufficient detail
488 for the covered person to respond further to the health carrier's
489 position;

490 (D) Reference to the documents, communications, information and
491 evidence used as the basis for the decision; and

492 (E) For a decision that upholds the adverse determination, a
493 statement (i) that the covered person may receive from the health
494 carrier, free of charge and upon request, reasonable access to and
495 copies of, all documents, communications, information and evidence
496 regarding the adverse determination that is the subject of the final
497 adverse determination, and (ii) disclosing the covered person's right to
498 contact the commissioner's office or the Office of the Healthcare
499 Advocate at any time, and that such covered person may benefit from
500 free assistance from the Office of the Healthcare Advocate, which can
501 assist such covered person with the filing of a grievance pursuant to 42
502 USC 300gg-93, as amended from time to time, or from the Division of
503 Consumer Affairs within the Insurance Department. Such disclosure
504 shall include the contact information for said offices.

505 (2) Upon request pursuant to subparagraph (E) of subdivision (1) of
506 this subsection, the health carrier shall provide such copies in
507 accordance with subsection (b) of section 38a-591n.

508 Sec. 4. Section 38a-591g of the 2014 supplement to the general
509 statutes is repealed and the following is substituted in lieu thereof
510 (*Effective January 1, 2015*):

511 (a) (1) A covered person or a covered person's authorized
512 representative may file a request for an external review or an
513 expedited external review of an adverse determination or a final
514 adverse determination in accordance with the provisions of this

515 section. All requests for external review or expedited external review
516 shall be made in writing to the commissioner. The commissioner may
517 prescribe the form and content of such requests.

518 (2) (A) All requests for external review or expedited external review
519 shall be accompanied by a filing fee of twenty-five dollars, except that
520 no covered person or covered person's authorized representative shall
521 pay more than seventy-five dollars in a calendar year for such covered
522 person. Any filing fee paid by a covered person's authorized
523 representative shall be deemed to have been paid by the covered
524 person. If the commissioner finds that the covered person is indigent
525 or unable to pay the filing fee, the commissioner shall waive such fee.
526 Any such fees shall be deposited in the Insurance Fund established
527 under section 38a-52a.

528 (B) The commissioner shall refund any paid filing fee to the covered
529 person or the covered person's authorized representative, as
530 applicable, or the health care professional if the adverse determination
531 or the final adverse determination that is the subject of the external
532 review request or expedited external review request is reversed or
533 revised.

534 (3) The health carrier that issued the adverse determination or the
535 final adverse determination that is the subject of the external review
536 request or the expedited external review request shall pay the
537 independent review organization for the cost of conducting the review.

538 (4) An external review decision, whether such review is a standard
539 external review or an expedited external review, shall be binding on
540 the health carrier or a self-insured governmental plan and the covered
541 person, except to the extent such health carrier or covered person has
542 other remedies available under federal or state law. A covered person
543 or a covered person's authorized representative shall not file a
544 subsequent request for an external review or an expedited external
545 review that involves the same adverse determination or final adverse
546 determination for which the covered person or the covered person's
547 authorized representative already received an external review decision

548 or an expedited external review decision.

549 (5) Each health carrier shall maintain written records of external
550 reviews as set forth in section 38a-591h.

551 (6) Each independent review organization shall maintain written
552 records as set forth in subsection (e) of section 38a-591m.

553 (b) (1) Except as otherwise provided under subdivision (2) of this
554 subsection or subsection (d) of this section, a covered person or a
555 covered person's authorized representative shall not file a request for
556 an external review or an expedited external review until the covered
557 person or the covered person's authorized representative has
558 exhausted the health carrier's internal grievance process.

559 (2) A health carrier may waive its internal grievance process and the
560 requirement for a covered person to exhaust such process prior to
561 filing a request for an external review or an expedited external review.

562 (3) If a covered person or the covered person's authorized
563 representative files a request for an external review or an expedited
564 external review pursuant to this section relating to the dispensation of
565 a drug prescribed by a licensed participating provider, the health
566 carrier shall issue immediate electronic authorization to the covered
567 person's pharmacy for the duration of any such grievance or review.
568 Such authorization shall include confirmation of the availability of
569 payment for such supply of such drug.

570 (c) (1) At the same time a health carrier sends to a covered person or
571 a covered person's authorized representative a written notice of an
572 adverse determination or a final adverse determination issued by the
573 health carrier, the health carrier shall include a written disclosure to
574 the covered person and, if applicable, the covered person's authorized
575 representative of the covered person's right to request an external
576 review.

577 (2) The written notice shall include:

578 (A) The following statement or a statement in substantially similar
579 language: "We have denied your request for benefit approval for a
580 health care service or course of treatment. You may have the right to
581 have our decision reviewed by health care professionals who have no
582 association with us by submitting a request for external review to the
583 office of the Insurance Commissioner, if our decision involved making
584 a judgment as to the medical necessity, appropriateness, health care
585 setting, level of care or effectiveness of the health care service or
586 treatment you requested.";

587 (B) For a notice related to an adverse determination, a statement
588 informing the covered person that:

589 (i) If the covered person has a medical condition for which the time
590 period for completion of an expedited internal review of a grievance
591 involving an adverse determination would seriously jeopardize the life
592 or health of the covered person or would jeopardize the covered
593 person's ability to regain maximum function, the covered person or the
594 covered person's authorized representative may (I) file a request for an
595 expedited external review, or (II) file a request for an expedited
596 external review if the adverse determination involves a denial of
597 coverage based on a determination that the recommended or
598 requested health care service or treatment is experimental or
599 investigational and the covered person's treating health care
600 professional certifies in writing that such recommended or requested
601 health care service or treatment would be significantly less effective if
602 not promptly initiated; and

603 (ii) Such request for expedited external review may be filed at the
604 same time the covered person or the covered person's authorized
605 representative files a request for an expedited internal review of a
606 grievance involving an adverse determination, except that the
607 independent review organization assigned to conduct the expedited
608 external review shall determine whether the covered person shall be
609 required to complete the expedited internal review of the grievance
610 prior to conducting the expedited external review;

611 (C) For a notice related to a final adverse determination, a statement
612 informing the covered person that:

613 (i) If the covered person has a medical condition for which the time
614 period for completion of an external review would seriously
615 jeopardize the life or health of the covered person or would jeopardize
616 the covered person's ability to regain maximum function, the covered
617 person or the covered person's authorized representative may file a
618 request for an expedited external review; or

619 (ii) If the final adverse determination concerns (I) an admission,
620 availability of care, continued stay or health care service for which the
621 covered person received emergency services but has not been
622 discharged from a facility, the covered person or the covered person's
623 authorized representative may file a request for an expedited external
624 review, or (II) a denial of coverage based on a determination that the
625 recommended or requested health care service or treatment is
626 experimental or investigational and the covered person's treating
627 health care professional certifies in writing that such recommended or
628 requested health care service or treatment would be significantly less
629 effective if not promptly initiated, the covered person or the covered
630 person's authorized representative may file a request for an expedited
631 external review;

632 (D) (i) A copy of the description of both the standard and expedited
633 external review procedures the health carrier is required to provide,
634 highlighting the provisions in the external review procedures that give
635 the covered person or the covered person's authorized representative
636 the opportunity to submit additional information and including any
637 forms used to process an external review or an expedited external
638 review;

639 (ii) As part of any forms provided under subparagraph (D)(i) of this
640 subdivision, an authorization form or other document approved by the
641 commissioner that complies with the requirements of 45 CFR 164.508,
642 as amended from time to time, by which the covered person shall
643 authorize the health carrier and the covered person's treating health

644 care professional to release, transfer or otherwise divulge, in
645 accordance with sections 38a-975 to 38a-999a, inclusive, the covered
646 person's protected health information including medical records for
647 purposes of conducting an external review or an expedited external
648 review;

649 (E) A statement that the covered person or the covered person's
650 authorized representative may request, free of charge, copies of all
651 documents, communications, information and evidence regarding the
652 adverse determination or the final adverse determination that were not
653 previously provided to the covered person or the covered person's
654 authorized representative.

655 (3) Upon request pursuant to subparagraph (E) of subdivision (2) of
656 this subsection, the health carrier shall provide such copies in
657 accordance with subsection (b) of section 38a-591n.

658 (d) (1) A covered person or a covered person's authorized
659 representative may file a request for an expedited external review of an
660 adverse determination or a final adverse determination with the
661 commissioner, except that an expedited external review shall not be
662 provided for a retrospective review request of an adverse
663 determination or a final adverse determination.

664 (2) Such request may be filed at the time the covered person
665 receives:

666 (A) An adverse determination, if:

667 (i) (I) The covered person has a medical condition for which the time
668 period for completion of an expedited internal review of the adverse
669 determination would seriously jeopardize the life or health of the
670 covered person or would jeopardize the covered person's ability to
671 regain maximum function; or

672 (II) The denial of coverage is based on a determination that the
673 recommended or requested health care service or treatment is
674 experimental or investigational and the covered person's treating

675 health care professional certifies in writing that such recommended or
676 requested health care service or treatment would be significantly less
677 effective if not promptly initiated; and

678 (ii) The covered person or the covered person's authorized
679 representative has filed a request for an expedited internal review of
680 the adverse determination; or

681 (B) A final adverse determination, if:

682 (i) The covered person has a medical condition where the time
683 period for completion of a standard external review would seriously
684 jeopardize the life or health of the covered person or would jeopardize
685 the covered person's ability to regain maximum function;

686 (ii) The final adverse determination concerns an admission,
687 availability of care, continued stay or health care service for which the
688 covered person received emergency services but has not been
689 discharged from a facility; or

690 (iii) The denial of coverage is based on a determination that the
691 recommended or requested health care service or treatment is
692 experimental or investigational and the covered person's treating
693 health care professional certifies in writing that such recommended or
694 requested health care service or treatment would be significantly less
695 effective if not promptly initiated.

696 (3) Such covered person or covered person's authorized
697 representative shall not be required to file a request for an external
698 review prior to, or at the same time as, the filing of a request for an
699 expedited external review and shall not be precluded from filing a
700 request for an external review, within the time periods set forth in
701 subsection (e) of this section, if the request for an expedited external
702 review is determined to be ineligible for such review.

703 (e) (1) Not later than one hundred twenty calendar days after a
704 covered person or a covered person's authorized representative
705 receives a notice of an adverse determination or a final adverse

determination, the covered person or the covered person's authorized representative may file a request for an external review or an expedited external review with the commissioner in accordance with this section.

(2) Not later than one business day after the commissioner receives a request that is complete, the commissioner shall send a copy of such request to the health carrier that issued the adverse determination or the final adverse determination that is the subject of the request.

(3) Not later than five business days after the health carrier receives the copy of an external review request or one calendar day after the health carrier receives the copy of an expedited external review request, from the commissioner, the health carrier shall complete a preliminary review of the request to determine whether:

(A) The individual is or was a covered person under the health benefit plan at the time the health care service was requested or, in the case of an external review of a retrospective review request, was a covered person in the health benefit plan at the time the health care service was provided;

(B) The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan but for the health carrier's determination that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(C) If the health care service or treatment is experimental or investigational:

(i) Is a covered benefit under the covered person's health benefit plan but for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition;

737 (ii) Is not explicitly listed as an excluded benefit under the covered
738 person's health benefit plan;

739 (iii) The covered person's treating health care professional has
740 certified that one of the following situations is applicable:

741 (I) Standard health care services or treatments have not been
742 effective in improving the medical condition of the covered person;

743 (II) Standard health care services or treatments are not medically
744 appropriate for the covered person; or

745 (III) There is no available standard health care service or treatment
746 covered by the health carrier that is more beneficial than the
747 recommended or requested health care service or treatment; and

748 (iv) The covered person's treating health care professional:

749 (I) Has recommended a health care service or treatment that the
750 health care professional certifies, in writing, is likely to be more
751 beneficial to the covered person, in the health care professional's
752 opinion, than any available standard health care services or treatments;
753 or

754 (II) Is a licensed, board certified or board eligible health care
755 professional qualified to practice in the area of medicine appropriate to
756 treat the covered person's condition and has certified in writing that
757 scientifically valid studies using accepted protocols demonstrate that
758 the health care service or treatment requested by the covered person
759 that is the subject of the adverse determination or the final adverse
760 determination is likely to be more beneficial to the covered person than
761 any available standard health care services or treatments;

762 (D) The covered person has exhausted the health carrier's internal
763 grievance process or the covered person or the covered person's
764 authorized representative has filed a request for an expedited external
765 review as provided under subsection (d) of this section; and

766 (E) The covered person has provided all the information and forms
767 required to process an external review or an expedited external review,
768 including an authorization form as set forth in subparagraph (D)(ii) of
769 subdivision (2) of subsection (c) of this section.

770 (4) (A) Not later than one business day after the preliminary review
771 of an external review request or the day the preliminary review of an
772 expedited external review request is completed, the health carrier shall
773 notify the commissioner, the covered person and, if applicable, the
774 covered person's authorized representative in writing whether the
775 request for an external review or an expedited external review is
776 complete and eligible for such review. The commissioner may specify
777 the form for the health carrier's notice of initial determination under
778 this subdivision and any supporting information required to be
779 included in the notice.

780 (B) If the request:

781 (i) Is not complete, the health carrier shall notify the commissioner
782 and the covered person and, if applicable, the covered person's
783 authorized representative in writing and include in the notice what
784 information or materials are needed to perfect the request; or

785 (ii) Is not eligible for external review or expedited external review,
786 the health carrier shall notify the commissioner, the covered person
787 and, if applicable, the covered person's authorized representative in
788 writing and include in the notice the reasons for its ineligibility.

789 (C) The notice of initial determination shall include a statement
790 informing the covered person and, if applicable, the covered person's
791 authorized representative that a health carrier's initial determination
792 that the request for an external review or an expedited external review
793 is ineligible for review may be appealed to the commissioner.

794 (D) Notwithstanding a health carrier's initial determination that a
795 request for an external review or an expedited external review is
796 ineligible for review, the commissioner may determine, pursuant to

797 the terms of the covered person's health benefit plan, that such request
798 is eligible for such review and assign an independent review
799 organization to conduct such review. Any such review shall be
800 conducted in accordance with this section.

801 (f) (1) Whenever the commissioner is notified pursuant to
802 subparagraph (A) of subdivision (4) of subsection (e) of this section
803 that a request is eligible for external review or expedited external
804 review, the commissioner shall, not later than one business day after
805 receiving such notice for an external review or one calendar day after
806 receiving such notice for an expedited external review:

807 (A) Assign an independent review organization from the list of
808 approved independent review organizations compiled and maintained
809 by the commissioner pursuant to section 38a-591l to conduct the
810 review and notify the health carrier of the name of the assigned
811 independent review organization. Such assignment shall be done on a
812 random basis among those approved independent review
813 organizations qualified to conduct the particular review based on the
814 nature of the health care service that is the subject of the adverse
815 determination or the final adverse determination and other
816 circumstances, including conflict of interest concerns as set forth in
817 section 38a-591m; and

818 (B) Notify the covered person and, if applicable, the covered
819 person's authorized representative in writing of the request's eligibility
820 and acceptance for external review or expedited external review. For
821 an external review, the commissioner shall include in such notice (i) a
822 statement that the covered person or the covered person's authorized
823 representative may submit, not later than five business days after the
824 covered person or the covered person's authorized representative, as
825 applicable, received such notice, additional information in writing to
826 the assigned independent review organization that such organization
827 shall consider when conducting the external review, and (ii) where and
828 how such additional information is to be submitted. If additional
829 information is submitted later than five business days after the covered

830 person or the covered person's authorized representative, as
831 applicable, received such notice, the independent review organization
832 may, but shall not be required to, accept and consider such additional
833 information.

834 (2) Not later than five business days for an external review or one
835 calendar day for an expedited external review, after the health carrier
836 receives notice of the name of the assigned independent review
837 organization from the commissioner, the health carrier or its designee
838 utilization review company shall provide to the assigned independent
839 review organization the documents and any information such health
840 carrier or utilization review company considered in making the
841 adverse determination or the final adverse determination.

842 (3) The failure of the health carrier or its designee utilization review
843 company to provide the documents and information within the time
844 specified in subdivision (2) of this subsection shall not delay the
845 conducting of the review.

846 (4) (A) If the health carrier or its designee utilization review
847 company fails to provide the documents and information within the
848 time period specified in subdivision (2) of this subsection, the
849 independent review organization may terminate the review and make
850 a decision to reverse the adverse determination or the final adverse
851 determination.

852 (B) Not later than one business day after terminating the review and
853 making the decision to reverse the adverse determination or the final
854 adverse determination, the independent review organization shall
855 notify the commissioner, the health carrier, the covered person and, if
856 applicable, the covered person's authorized representative in writing
857 of such decision.

858 (g) (1) The assigned independent review organization shall review
859 all the information and documents received pursuant to subsection (f)
860 of this section. In reaching a decision, the independent review
861 organization shall not be bound by any decisions or conclusions

862 reached during the health carrier's utilization review process.

863 (2) Not later than one business day after receiving any information
864 submitted by the covered person or the covered person's authorized
865 representative pursuant to subparagraph (B) of subdivision (1) of
866 subsection (f) of this section, the independent review organization
867 shall forward such information to the health carrier.

868 (3) (A) Upon the receipt of any information forwarded pursuant to
869 subdivision (2) of this subsection, the health carrier may reconsider its
870 adverse determination or the final adverse determination that is the
871 subject of the review. Such reconsideration shall not delay or terminate
872 the review.

873 (B) The independent review organization shall terminate the review
874 if the health carrier decides, upon completion of its reconsideration
875 and notice to such organization as provided in subparagraph (C) of
876 this subdivision, to reverse its adverse determination or its final
877 adverse determination and provide coverage or payment for the health
878 care service or treatment that is the subject of the adverse
879 determination or the final adverse determination.

880 (C) Not later than one business day after making the decision to
881 reverse its adverse determination or its final adverse determination,
882 the health carrier shall notify the commissioner, the assigned
883 independent review organization, the covered person and, if
884 applicable, the covered person's authorized representative in writing
885 of such decision.

886 (h) In addition to the documents and information received pursuant
887 to subsection (f) of this section, the independent review organization
888 shall consider, to the extent the documents or information are available
889 and the independent review organization considers them appropriate,
890 the following in reaching a decision:

891 (1) The covered person's medical records;

892 (2) The attending health care professional's recommendation;

893 (3) Consulting reports from appropriate health care professionals
894 and other documents submitted by the health carrier, the covered
895 person, the covered person's authorized representative or the covered
896 person's treating health care professional;

897 (4) The terms of coverage under the covered person's health benefit
898 plan to ensure that the independent review organization's decision is
899 not contrary to the terms of coverage under such health benefit plan;

900 (5) The most appropriate practice guidelines, which shall include
901 applicable evidence-based standards and may include any other
902 practice guidelines developed by the federal government, national or
903 professional medical societies, medical boards or medical associations;

904 (6) Any applicable clinical review criteria developed and used by
905 the health carrier or its designee utilization review company; and

906 (7) The opinion or opinions of the independent review
907 organization's clinical peer or peers who conducted the review after
908 considering subdivisions (1) to (6), inclusive, of this subsection.

909 (i) (1) The independent review organization shall notify the
910 commissioner, the health carrier, the covered person and, if applicable,
911 the covered person's authorized representative in writing of its
912 decision to uphold, reverse or revise the adverse determination or the
913 final adverse determination, not later than:

914 (A) For external reviews, forty-five calendar days after such
915 organization receives the assignment from the commissioner to
916 conduct such review;

917 (B) For external reviews involving a determination that the
918 recommended or requested health care service or treatment is
919 experimental or investigational, twenty calendar days after such
920 organization receives the assignment from the commissioner to
921 conduct such review;

922 (C) For expedited external reviews, except as specified under

923 subparagraph (D) of this subdivision, as expeditiously as the covered
924 person's medical condition requires, but not later than seventy-two
925 hours after such organization receives the assignment from the
926 commissioner to conduct such review;

927 (D) For expedited external reviews involving a health care service or
928 course of treatment specified under subparagraph (B) or (C) of
929 subdivision (38) of section 38a-591a, as expeditiously as the covered
930 person's medical condition requires, but not later than twenty-four
931 hours after such organization receives the assignment from the
932 commissioner to conduct such review; and

933 (E) For expedited external reviews involving a determination that
934 the recommended or requested health care service or treatment is
935 experimental or investigational, as expeditiously as the covered
936 person's medical condition requires, but not later than five calendar
937 days after such organization receives the assignment from the
938 commissioner to conduct such review.

939 (2) Such notice shall include:

940 (A) A general description of the reason for the request for the
941 review;

942 (B) The date the independent review organization received the
943 assignment from the commissioner to conduct the review;

944 (C) The date the review was conducted;

945 (D) The date the organization made its decision;

946 (E) The principal reason or reasons for its decision, including what
947 applicable evidence-based standards, if any, were used as a basis for its
948 decision;

949 (F) The rationale for the organization's decision;

950 (G) Reference to the evidence or documentation, including any
951 evidence-based standards, considered by the organization in reaching

952 its decision; and

953 (H) For a review involving a determination that the recommended
954 or requested health care service or treatment is experimental or
955 investigational:

956 (i) A description of the covered person's medical condition;

957 (ii) A description of the indicators relevant to determining whether
958 there is sufficient evidence to demonstrate that (I) the recommended or
959 requested health care service or treatment is likely to be more
960 beneficial to the covered person than any available standard health
961 care services or treatments, and (II) the adverse risks of the
962 recommended or requested health care service or treatment would not
963 be substantially increased over those of available standard health care
964 services or treatments;

965 (iii) A description and analysis of any medical or scientific evidence
966 considered in reaching the opinion;

967 (iv) A description and analysis of any evidence-based standard; and

968 (v) Information on whether the clinical peer's rationale for the
969 opinion is based on the documents and information set forth in
970 subsection (f) of this section.

971 (3) Upon the receipt of a notice of the independent review
972 organization's decision to reverse or revise an adverse determination
973 or a final adverse determination, the health carrier shall immediately
974 approve the coverage that was the subject of the adverse determination
975 or the final adverse determination.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2015</i>	38a-591d
Sec. 2	<i>January 1, 2015</i>	38a-591e
Sec. 3	<i>January 1, 2015</i>	38a-591f
Sec. 4	<i>January 1, 2015</i>	38a-591g

INS *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact:

Municipalities	Effect	FY 15 \$	FY 16 \$
Various Municipalities	Cost	Potential	Potential

Explanation

There is no cost to the state employee and retiree health plan as a result of this bill as the state as a self-insured plan is considered an employer and not a carrier for the purposes of the utilization and review procedures outlined in CGS 38a-591d.

It is uncertain if the bill's provisions would increase costs to fully-insured municipal plans whose health insurers do not currently follow the dispensing procedures required by the bill. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts on or after January 1, 2015. Due to federal law, municipalities with self-insured health plans are exempt from state health insurance benefit mandates.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis**SB 186*****AN ACT CONCERNING DISPENSATION AND INSURANCE COVERAGE OF A PRESCRIBED DRUG DURING REVIEW OF AN ADVERSE DETERMINATION OR A FINAL ADVERSE DETERMINATION.*****SUMMARY:**

This bill requires health insurers to authorize an insured's pharmacy to fill a prescription if the insured or his or her authorized representative files a grievance or requests a review of an adverse determination (e.g., a claim denial), or final adverse determination related to dispensing a drug prescribed by a licensed participating provider. The authorization must be made immediately and electronically and must continue for the duration of the grievance or review. The insurer must confirm that it will pay for the supply of the drug during that time.

EFFECTIVE DATE: January 1, 2015

BACKGROUND***Adverse Determinations***

By law, a health insurer must promptly provide an insured and, if applicable, his or her authorized representative with a notice of an adverse determination. At the request of the insured, the insurer must review adverse determinations and notify the insured and, if applicable, his or her authorized representative of its decision following a review of its determination. The insured or the insured's authorized representative may request an external review of an adverse or a final adverse determination.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 11 Nay 8 (03/04/2014)